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# A Group Design for HIV-Negative Gay Men

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*The social work and psychotherapeutic literature is replete with information on the psychosocial needs of HIV-positive gay men and gay men living with AIDS. However, scant information focuses on an often-overlooked population: HIV-negative gay men. This article examines the development of a group design that addresses the unique psychosocial needs of HIV-negative gay men. A 12-week, time-limited group focused on the effects of the AIDS epidemic on HIV-negative gay men's psychosocial functioning, including its potential exacerbation of common developmental issues such as exclusion, loss, survivor guilt, and lack of validation; the use of insight interventions and psychosocial problem solving; and the development of a working focus and group goals to improve psychosocial functioning in this population. Initial evaluations by group members using this design show promise; however, empirical evidence is essential to verify its effectiveness.*

**Key words:** *gay men; group design; HIV/AIDS; HIV negative; psychosocial issues*

The AIDS epidemic has profound psychosocial significance for the gay community. Many urban gay communities, which include both HIV-negative and HIV-positive men, have met the challenges of the HIV epidemic with ingenuity, resilience, unparalleled behavior changes, and volunteerism and giving (Paul, Hays, & Coates, 1995). Gay men were the first to respond to the epidemic (Popham et al., 1983) and to date have accounted for the largest number of AIDS cases (Centers for Disease Control and Prevention [CDC], 1994). Moreover, gay men continue to be largely responsible for implementing programs to reduce the incidence of HIV infection among themselves. However, some gay men experience an extreme sense of hopelessness, an inability to imagine a

viable future, and related psychological issues that must be recognized and addressed (Odets, 1994).

For more than a decade, social workers and other health care practitioners have concentrated their efforts on the psychosocial needs of gay men infected with HIV and those living with AIDS (Dane, 1989; Dowd, 1995; Icard, Schilling, El-Bassel, & Young, 1992; Lopez & Getzel, 1984; Nichols, 1986; Sheran, 1995). Gay men not infected with HIV, however, are significantly underrepresented in the social work and psychotherapeutic literature. HIV-negative gay men are potential survivors of a community devastated by AIDS and as such have psychosocial needs that differ from those of HIV-positive gay men. When these needs are neglected, psychosocial



functioning may decrease, thus increasing risk for HIV infection. As HIV infection rates continue to rise steadily among gay men (Stall, 1994), it is imperative that HIV education, services, and prevention programs differentiate between HIV-negative and HIV-positive gay men.

This article focuses on HIV-negative gay men and their psychosocial needs and examines one design for group work practice. The author discusses establishing a time-limited therapy group for HIV-negative gay men, including formulating a group focus and goals, screening group members, and establishing a group structure, and explains the stages of group therapy that were developed for this population. A case study and discussion are presented.

The material in this article was taken from the author's clinical experience leading five time-limited therapy groups at the New York Blood Center Project ACHIEVE, an HIV vaccine research initiative in New York City. The goal of this project is to study HIV-negative gay men's sexual practices and incidence of new HIV infection to ascertain whether this population is a suitable group to participate in upcoming trials of vaccines (personal communication with B. Koblin, epidemiologist, New York Blood Center, September 20, 1995). Group members were self-referred HIV-negative gay men residing in a large urban community. Ages ranged from 26 to 54. The men were white or Latino and were college educated.

The author acknowledges the difficulty in writing about this population, particularly when using the terms "gay" and "HIV negative," without perpetuating myths of sameness. The reader is asked to consider that every generalization must be reassessed when applied to the individual and that the lives of HIV-negative gay men are as varied as those of the people reading this article.

## Literature Review

### Psychosocial Issues

The literature on the impact of the AIDS epidemic on HIV-negative gay men's psychosocial functioning is just emerging. It is clear, however, that the AIDS epidemic has exacerbated specific developmental issues that are common to many HIV-negative gay men as they form a cohesive "gay identity": exclusion, lack of validation, loss, and guilt (Isay, 1989; Isensee, 1991; Odets, 1994, 1995a, 1995b).

The literature has shown pervasive evidence of AIDS stigmatization (for example, discrimination and violence) of those who are at risk for contracting HIV (Dane & Miller, 1992; Patton, 1992; Paul et al., 1995). Even though they are not infected, many HIV-negative gay men are identified with AIDS and excluded from society because they are connected to a feared disease. Moreover, because society views all gay men as being infected with HIV or having AIDS, many HIV-negative gay men can no longer clearly distinguish a gay identity from having HIV, developing AIDS, or experiencing an early death (Odets, 1994). This meshing of the AIDS epidemic and homosexuality can produce a blurring of one's gay identity with having HIV or AIDS. Furthermore, some within the gay community feel that focusing on the needs of HIV-negative gay men takes away much-needed care from HIV-positive gay men, resulting in the exclusion of this population from essential services (Odets, 1995b).

Many HIV-negative gay men's lives are also marked by constant fear of contracting HIV, developing illness, and ultimately dying. According to Morris and Dean (1994), one-third to half of gay men in certain major urban centers may be infected with HIV. The possibility of contracting HIV is a continual threat for sexually active HIV-negative gay men. Consequently, some members of this population live in a persistent state of uncertainty, commonly voiced as, "How long will I remain negative?" (Odets, 1995a; Paul et al., 1995). Often these experiences of the epidemic are not validated by society, which for the most part has failed to acknowledge the magnitude of the epidemic.

In addition, the multiple losses that HIV-negative gay men experience from AIDS-related deaths within the gay community produce social withdrawal and isolation. For some HIV-negative gay men, entire social networks have been wiped out by AIDS. In an attempt to alleviate the emotional drain and fear of facing yet another loss, some HIV-negative gay men avoid those who are ill (Paul et al., 1995). Fear of infection may also lead many in this population to distance themselves from those who are HIV infected, creating further isolation.

The AIDS epidemic also gives rise to guilt, in particular survivor guilt. A prevalent phenomenon among many HIV-negative gay men is guilt about surviving the epidemic themselves or not



doing enough for those who are ill or have not survived. A negative status may be experienced as a betrayal or an abandonment of those who are infected (Dane & Miller, 1992; Odets, 1995a, 1995b; Paul et al., 1995). Survivor guilt frequently manifests itself in dysfunctional behaviors such as unprotected sex, substance abuse, difficulty planning for the future, and resistance to intimate relationships (Odets, 1995b).

Clearly, the effects of the AIDS epidemic on potential or pre-existing developmental conflicts are important considerations when providing services to HIV-negative gay men. Social exclusion, failure to find validation, loss, and survivor guilt must be addressed because they may generate poor self-esteem, depression, hopelessness, and a sense of fatalism (Hawkins, 1993; Isay, 1989; Odets, 1994).

### Use of Time-Limited Group Therapy

Group work has been used as an effective intervention for improving the psychosocial functioning of gay men struggling with various issues related to the AIDS epidemic (Gambe & Getzel, 1989; Hawkins, 1993; Isensee, 1991; Land & Harangody, 1990; Lenihan, 1985). HIV-negative gay men can also benefit from a group experience. Although individual therapeutic interventions can be beneficial, group modalities are highly effective when addressing survivor issues (Dane & Miller, 1992; Hartman, 1983; Knight, 1990). Group experiences, specifically therapy groups (Odets, 1995a), are recommended for HIV-negative gay men as survivors (Paul et al., 1995) and for HIV-negative gay men requiring AIDS prevention interventions (Klotz, 1995; Roffman, Gillmore, Gilchrist, Mathias, & Krueger, 1990). Furthermore, Isbell and Goldenberg (1995) reported that a therapy group can help HIV-negative gay men overcome the psychological obstacles to health promotion, including multiple loss, grief, survivor guilt, fatalism, and depression.

Therapy groups offer an interpersonal experience in which the social environment of the group provides resolution of intrapsychic conflict. This social microcosm (Yalom, 1985) cannot be pro-

vided by individual psychotherapy. Although one modality should not be substituted for the other, the therapy group is an excellent intervention for mutual understanding and identification of important issues. Because HIV-negative gay men may share psychosocial issues, in particular survivor guilt, HIV-negative gay identity, and disenfranchisement in some larger gay communities (Odets, 1995a), the therapy group provides an opportunity for them to solidify an identity as HIV-negative gay men among others who share a similar experience (Odets, 1995a). Moreover, through psychosocial problem solving (Gambe & Getzel, 1989), HIV-negative gay men can engage in a process of mutual aid. As such, group members can exchange information on practical efforts

at problem solving to deal with the AIDS epidemic, sexual practices, HIV-negative and HIV-positive relationships, and other interpersonal relationships.

The advantages of time-limited group therapy are noted throughout the literature (Budman, Demby, Feldstein, & Gold, 1984; Budman & Gurman, 1988; Johnson & Gelso, 1980; Klein, 1993; Ursano & Dressler, 1974). Ongoing group psychotherapy can be expensive, time consuming, and unavail-

able. Therefore, time-limited group therapy is indicated as a more expansive method for reaching this population (Klein, 1993; Knight, 1990; Odets, 1995a). Historically, time-limited group therapy has also been used with groups focused on narrowly defined problems or patient populations (Klein, 1993). Thus, because HIV-negative gay men are a homogeneous group sharing common issues within a cultural and social context, time-limited group therapy is warranted. Homogeneous groups can provide immediate identification and cohesion, encourage better attendance, and move quickly into the working phase (Budman & Gurman, 1988; Klein, 1993). Furthermore, a time-limited therapy group minimizes member dependency and enhances member motivation to work (Klein, 1993; Knight, 1990). These elements are largely lacking in ongoing therapy groups.

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Time-limited homogeneous groups also provide powerful social networks and a shared sense of commonality (Klein, 1993). Through the response and interaction of other group members, HIV-negative gay men are provided with a place to feel validated (Klein, 1993). Some HIV-negative gay men may also struggle with social exclusion. As such, the therapy group concept of universality (Yalom, 1985) can help group members greatly as they comprehend that they are not alone in their feelings, fears, and actions. In addition, a time-limited group experience provides HIV-negative gay men with a new sense of hope as they observe improvement in other group members (Yalom, 1985). With the profound sense of fatalism experienced by some in this population, a group encounter that offers optimism can be effective in alleviating hopelessness and despair. Through emphasizing the feeling of belonging, time-limited therapy groups can empower group members, allowing for growth and increased self-esteem. This is especially vital for HIV-negative gay men who through exclusion, alienation, and isolation have developed poor self-concept and low self-esteem.

### **Time-Limited Therapy Groups for HIV-Negative Gay Men**

#### **Focus and Goals**

The working focus of the time-limited therapy groups developed by the author targeted issues of psychosocial importance shared by HIV-negative gay men. Group goals were directly related to the working focus (Budman & Gurman, 1988) and included issues related to individual and group identity as HIV-negative gay men, the AIDS epidemic, relationships and intimacy, and sexual practices. The emergent focus of the groups differed from the working focus and developed over the course of the group. Although group members shared concerns as HIV-negative gay men, they nonetheless were unique individuals and addressed in varying ways issues that arose throughout the group's duration (Budman & Gurman, 1988).

Foremost of the goals was acknowledging one's identity as an HIV-negative gay man: "Being gay and being uninfected is now a condition, not the absence of one. Being uninfected is a personal and social identity, like being gay, and it must be similarly clarified, consolidated, and acknowledged in the world. Being uninfected thus involves pre-

cisely the kind of 'coming out' process that being gay does" (Odets, 1995a, p. 15). Members required assistance in moving beyond any denial they had about their experience as survivors and in recognizing and accepting the extent to which they had been affected by the AIDS epidemic. Acknowledgment of their unique identity as HIV-negative gay men as well as of the feelings associated with that identity allowed group members to overcome denial of the impact of HIV in their lives as gay men. Such denial stemmed from individual and societal attitudes (Odets, 1995a).

Group members also acknowledged difficult and painful feelings such as loss, shame, and guilt. The men required a safe place to acknowledge publicly their sense of helplessness as they watch loved ones, friends, and the gay community continue to be devastated by the epidemic. They also required help in expressing these feelings. Furthermore, some members needed help articulating angry or shameful feelings experienced as a result of stigmatization.

Another group goal was to reduce feelings of isolation. For the most part, group members did not have an array of therapeutic services to assist them with their psychosocial issues related to HIV negativity. Consequently, many men withdrew and isolated themselves. Through relationships established in the group, however, members could work interpersonally on intimacy and trust issues, alleviating isolation. Thus, the group was a vehicle for these men to examine current relationships and to acknowledge existing troubling patterns.

Finally, the group assisted members with issues related to sexual practices. Some gay men have been unable to maintain safer sexual practices over long periods of time (Booth, 1994; Paul et al., 1995; Perlman, 1994; Stall, 1994; Staver, 1992). In many cities gay men are the population at greatest risk for AIDS and HIV. For example, the CDC (1994) reported that more than 60 percent of nationwide AIDS cases are gay men. Consequently, gay men have been bombarded with safer-sex information intended to reduce HIV risk. Unfortunately, much of that information has been conflicting. A goal of the group was to provide members with the opportunity to discuss feelings of confusion, uncertainty, low self-worth, loneliness, and anxiety, which may lead to unprotected sexual behavior. Addressing the psychosocial factors contributing to unprotected sexual behaviors enhanced individual and group self-esteem, created



a greater sense of community, enhanced individual and group determination to survive the epidemic, and helped members develop a shared sense of a future apart from the epidemic (Tuller, 1993). Furthermore, by discussing the consequences of unprotected sexual behavior and the feelings of sadness, anger, and mourning as they related to sexual practices, group members were helped to reduce their HIV risk (Roan, 1992; Shernoff, 1988).

### Screening

The purpose of screening was to assess a prospective group member's ability to benefit from a group experience; to assess his potential to help others as a group member; to obtain information from him about previous and current experiences with individual and group therapy, including presenting problems such as depression, hypochondriasis, anxiety, panic attacks, and obsessions; to ask him to articulate goals for his participation in the group and help him reframe his presenting problem in a way that was relevant to the working focus of the group; and to discuss the ground rules for group participation.

A requirement for group functioning was limiting membership to gay men who believed themselves to be HIV negative. A mixed group of HIV-negative and HIV-positive gay men would have had great difficulty honestly addressing issues of guilt and of positive and negative relations (Odets, 1995a). The potential member's ability to recognize and acknowledge his experience as an HIV-negative gay man was a crucial criterion for inclusion. An applicant who used denial in dealing with his experience as a survivor of the AIDS epidemic was not ready for the demands of the group. Criteria for inclusion also included a high level of motivation for group therapy (Yalom, 1985) and a demonstrated ability to interact interpersonally, communicate in a group setting, and express and discuss issues relevant to the group's focus.

Choosing applicants who were psychologically compatible was important. Members who were more or less psychologically developed could have drawn attention away from the group's focus and could have damaged the group's constructed standard. Psychotic, severely depressed, withdrawn, hostile, or aggressive members would have been inappropriate and unproductive. Age was not found to be an important factor for eligibility in

the groups; in fact, the life experiences of members of differing ages proved beneficial.

During the screening interview, the group was described as a means for interpersonal exploration of issues relevant to one's identity as an HIV-negative gay man. The applicant's presenting problem was reframed in a way that was relevant to this working focus. The applicant was informed that weekly attendance was expected. His ability and motivation to commit himself to a 12-week group were assessed. In addition, during the screening process, the group leader began working on apparent issues of isolation as similarities in life circumstances between the applicant and other group members were discussed.

### Structure

Unlike support group designs, which concentrate on emotional support to strengthen existing psychological defenses against conflict, the therapy group design focused on improving group members' psychosocial functioning through the use of psychosocial problem solving and of insight interventions to clarify psychological conflict for resolution within the group setting (Budman & Gurman, 1988; Odets, 1995a; Yalom, 1985). As the members developed interpersonal relationships within the group, the group provided members with insight that allowed them to overcome obstacles to optimal psychosocial functioning (Odets, 1995a). Because the AIDS epidemic had placed some of the group members in a vulnerable psychological and social situation, leaving them at high risk for HIV infection, it was imperative to encourage safe expression of honest feelings to achieve genuine and enduring results. Insight interventions, not solely supportive techniques, helped to ensure this (Odets, 1995a).

Each group was structured to meet once weekly for 1½ hours and was limited to eight to 10 members (Yalom, 1985) to ensure the establishment of intimate relationships and to increase the probability of accomplishing group goals. Issues such as confidentiality were stressed. Members were asked to refrain from meeting with other group members outside of the group. If they did meet outside of the group, they were requested to bring back to the group the implications of this interaction. Setting limits on outside contact for HIV-negative gay men may seem questionable, especially considering the detrimental effect the AIDS epidemic has had on entire social networks within



the gay community, depriving many gay men of the benefits of social support (Paul et al., 1995). In the case of a time-limited therapy group, however, limiting outside contact among members was appropriate, given that honest and safe communication within the group may be inhibited by the formation of close friendships outside the group.

## Development

The groups adhered to five general stages of group development suggested by Budman and Gurman (1988): (1) starting the group (session 1); (2) early therapy (sessions 2 to 4); (3) middle of the group (sessions 5 to 7); (4) late therapy (sessions 8 to 10); and (5) termination (sessions 11 to 12). After session 1 the therapy groups usually developed quickly, perhaps because of the time-limited nature of the groups and the homogeneity of group members. Nonetheless, session 1 was usually slow. Because of overriding safety issues, the group members initially hesitated to engage in interpersonal interaction. This hesitance was alleviated during the group's beginning activity of introductions and statements of reasons for attending the group. Through this activity, cohesion began and members realized they were neither alone nor unique in their experiences. The leader emphasized the group's working focus on "interpersonal exploration of issues relevant to HIV-negative identity." Each session began with a statement such as "This is the first session of 12. Eleven sessions remain." In addition, the leader attempted to illustrate intermember similarities to promote cohesion and encourage interpersonal interaction. For example, "B just described his feelings of isolation as he has lost all of his closest friends to AIDS. Everyone in the group has probably felt some sense of isolation due to losing friends."

During sessions 2 through 4, members addressed the concerns and issues that brought them to the group. As self-disclosure increased, anxiety lessened and mutuality and cohesiveness continued to develop (Knight, 1990). The group leader helped members clarify how the working focus of the group applied to each of them as individuals. For example, because of predominant feelings of

guilt, some members tended to focus on their losses from the AIDS epidemic by recounting the illnesses and experiences of their HIV-positive friends and lovers, often denying their own experiences and feelings related to being HIV negative. Given that trust and safety had not yet fully developed, the leader intervened with the group at times, bringing the members back to the group's working focus, for example, "C, it sounds like your friend is really struggling with his AIDS diagnosis; however, I'm wondering how you feel about his diagnosis given that you are not HIV infected." It was also the group leader's continual task during this stage to teach members cohesion-related skills. For example, a sense of group connectedness was enhanced as the leader regularly

intervened with questions such as, "H, how did you react when J just said he feels guilty when talking to his HIV-positive friends about his own problems, as he feels their HIV-related problems are much more significant than his own?"

During sessions 5 through 7, a sense of uncertainty and panic often developed as the group neared the halfway

mark. Members often began feeling that their expectations were not being met in the group. Often the working focus of the group was related to the group's panic. For example, a central goal for members was establishing an identity as being HIV uninfected. Thus, members' identity problems related to their HIV negativity were often closely related to their frustration and panic, for example, "L, I hear you are saying that you are frustrated, because you have wanted to talk about safer-sex practices since the beginning of the group. I'm wondering if it might be difficult to ask that your needs to be met here in the group, especially because you have mentioned that it is sometimes difficult to ask your lover to meet your needs, because you feel badly because he is physically ill much of the time?" In this illustration, L was frustrated because he was unable to ask for what he wanted in the group, which was related to his inability to recognize his needs and issues related to being HIV negative. Like other group members, L was unable to articulate these needs because of unrecognized feelings of guilt, in L's

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*The leader attempted to illustrate intermember similarities to promote cohesion and encourage interpersonal interaction.*

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case survivor guilt in relation to his lover. However, through insight interventions (for example, clarification, confrontation, and interpretation), L and other group members continued to come together as they addressed the group's working focus, gained insight into their issues, and learned that the primary source of help would be in helping each other.

During sessions 8 through 10, group members shared more and worked on issues on a deeper level. The leader intervened less often, with group members raising questions and refocusing members when others got off track. The group commonly addressed intimacy and relationship issues as well as sexual practices more candidly during this stage. As safer-sex practices were discussed, members exchanged information and strategies for remaining HIV uninfected. Through supporting each other in their struggles to move on with their lives, members began to visualize a future apart from the epidemic.

During sessions 11 and 12, the group leader helped members review what they had learned in dealing with the working focus of the group and discuss what changes had occurred for them as a result of participating in the group. Common responses were "I feel more confident about my sexual practices having talked about them in a safe place with others who can relate to my situation" and "I feel like it is OK to have a future and be happy, even though some of my friends and family may be struggling with AIDS." During this stage, old losses re-emerged, and cohesion was at its strongest. The leader helped members maintain this closeness while separating. In addition, members often requested that more sessions be added. The leader stood firm in concluding the group within the stated time. Major benefits were not likely to be gained by adding sessions. The members took with them what they had received from the group and reflected on their experiences. Some members exchanged phone numbers at the end of the last session, which was helpful for some who were isolated because of multiple AIDS-related losses.

### Case Study

C, age 30, was single and white and the youngest of two sons raised in a two-parent, middle-class household. C reported a tenuous relationship with his older brother, who constantly teased him while growing up. His father seemed to favor the

elder son, who was highly skilled at sports, something C felt his father admired. C presented with complaints of isolation precipitated by a close friend's death from AIDS four months earlier. C entered the group to work on issues related to being HIV negative, in particular unresolved issues related to the loss of his friend. In addition, C stated he was constantly anxious because he engaged in what he considered sexually compulsive behavior. C reported his concerns about practicing safer sex, maintaining his HIV-negative status, and his inability to maintain a satisfying love relationship.

C remained quiet during the first few sessions, interacting only when encouraged by other group members. During session 4, however, C became angry at another group member after he requested that C participate more in the group. The leader explored C's feelings, and C revealed that he was angry that the leader did not intervene and tell the other member to leave him alone. The leader wondered if C was not really angry at his father for favoring C's older brother and not protecting him from his brother's taunts. C accepted this interpretation and in the following session shared his feelings of shame and guilt related to being gay and "not being what his father wanted him to be," resulting in what he referred to as low self-esteem. Group members confronted C about the inaccurate image he had of himself while at the same time emphasizing his strengths and accomplishments, for example, having a successful career and reaching out for help with his issues.

In the remaining sessions, C spoke about the loss of his best friend to AIDS and in particular his feelings of guilt for surviving the epidemic. Through listening to others' feelings and thoughts on issues related to being HIV negative, C stated that his own feelings were validated. Toward the end of the group, C reported that he was able to contact his close friend's parents about his relationship with their son and that he was no longer sexually acting out. C reported that he felt there was a correlation between his sexual compulsivity and his unresolved feelings about his friend's death. For example, to avoid difficult feelings related to contacting his close friend's parents, such as loss, death, and his own immortality, C engaged in what for him was compulsive, anonymous, and ultimately ungratifying sex. C reported that the group assisted him in seeing this pattern because it provided him with a space to have his



feelings validated and supported. As the group ended, C stated that he was beginning to re-examine what he wanted from a loving relationship and from the future.

## Discussion and Conclusion

A time-limited therapy group design offered HIV-negative gay men some optimism in the AIDS prevention arena. When members evaluated the effectiveness of the group in follow-up anonymous questionnaires, a significant number indicated that their expectations on entering the group were met within the 12 weeks. In addition, most reported that sharing thoughts and feelings with other HIV-negative gay men helped them more clearly understand their sexual practices, their interactions with other men, and the issues they faced as HIV-negative gay men living during the AIDS epidemic. Furthermore, most members reported being more conscious and aware of sexual behaviors that can lead to increased HIV risk. Many reported gaining confidence in negotiating safer sex with their partners and a new sense of hope to move forward in their lives.

The use of time-limited group therapy has received empirical and theoretical support from the literature concerning overall group work. However, because of the dearth of literature on the use of this or other interventions with HIV-negative gay men, group therapy relies most often on the individual work of the social worker. More systematic evaluation and evidence showing time-limited group therapy as an effective intervention plan with this population are needed. As survivors of the AIDS epidemic, HIV-negative gay men present with specific psychosocial needs that differ from those of their HIV-positive counterparts. Therefore, as HIV infection rates continue to rise among gay men (Stall, 1994), AIDS education, prevention programs, and services must differentiate between HIV-negative and HIV-positive gay men. This article has demonstrated theoretical support for the use of a time-limited therapy group design with HIV-negative gay men. However, further empirical and systematic evaluation of this and other interventions targeted toward this population is essential. ■

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